

SERFF Tracking Number:	NWPA-125869610	State:	Arkansas
Filing Company:	Nationwide Life and Annuity Insurance Company	State Tracking Number:	40725
Company Tracking Number:	LAA-0109M1		
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	M Multi-Application for Life Insurance		
Project Name/Number:	/		

## Filing at a Glance

Company: Nationwide Life and Annuity Insurance Company

Product Name: M Multi-Application for Life Insurance      SERFF Tr Num: NWPA-125869610 State: ArkansasLH

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 40725

Sub-TOI: L08.000 Life - Other

Co Tr Num: LAA-0109M1

State Status: Approved-Closed

Filing Type: Form

Co Status: Pending

Reviewer(s): Linda Bird

Authors: Andrea Sgobbo, Clara Pollard

Disposition Date: 10/31/2008

Date Submitted: 10/30/2008

Disposition Status: Approved

Implementation Date Requested: 01/01/2009

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This form is being filed concurrently in our state of domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/31/2008

State Status Changed: 10/31/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

LAA-0109M1, Application for Life Insurance

NAIC #92657

Enclosed for filing, subject to your approval, is form LAA-0109M1, Application for Life Insurance. This is a new form and will replace form L-4736-99, Application for Life Insurance (approved 01/15/2003). We will begin using form LAA-

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0109M1 on the latter of January 1, 2009 or upon approval.

Form LAA-0109M1, will be used with our Traditional, Universal Life, Variable Life and Variable Universal Life Products. Form VLS-0109AO, Variable Life Fund Supplement (approved 12/05/2007), will be used with this application.

The intended purpose of form LAA-0109M1, Application for Life Insurance, is to update our multi application to provide an easier application process for our producers and customers. The forms will be completed by the Agent/Broker in their entirety in paper form only. We have plans to use these forms electronically at a later date.

This form is being filed concurrently in our state of domicile. Form LAA-0109M1 has been written in a readable fashion and attains a Flesch score of 44.2; however, when combined with the policy the score is greater than 50.

Thank you in advance for your attention to this matter. Please call me if you have any questions on this filing.

Clara J. Pollard  
Senior Analyst  
NF Regulatory Filings &  
Operations Team, 1-33-102  
Phone: (800) 691-0023 ext. 9-4507  
Fax: (614) 249-2112

Enclosures:

1. Filing Fee – via EFT
2. Certification
3. Form LAA-0109M1, Application for Life Insurance

## Company and Contact

### Filing Contact Information

Clara Pollard, Sr. Analyst  
One Nationwide Plaza  
Columbus, OH 43215

pollarc@nationwide.com  
(614) 249-4507 [Phone]

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**Filing Company Information**

Nationwide Life and Annuity Insurance Company	CoCode: 92657	State of Domicile: Ohio
One Nationwide Plaza	Group Code: 140	Company Type:
1-10-03		
Columbus, OH 43215	Group Name:	State ID Number:
(800) 882-2822 ext. [Phone]	FEIN Number: 31-1000740	
	-----	

SERFF Tracking Number: NWPA-125869610 State: Arkansas

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## Filing Fees

Fee Required? Yes

Fee Amount: \$50.00

Retaliatory? Yes

Fee Explanation: retaliatory fee for domicile state.

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life and Annuity Insurance Company	\$50.00	10/30/2008	23582595

SERFF Tracking Number: NWPA-125869610 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/31/2008	10/31/2008

*SERFF Tracking Number:*      *NWPA-125869610*      *State:*      *Arkansas*  
*Filing Company:*      *Nationwide Life and Annuity Insurance Company* *State Tracking Number:*      *40725*  
*Company Tracking Number:*      *LAA-0109M1*  
*TOI:*      *L08 Life - Other*      *Sub-TOI:*      *L08.000 Life - Other*  
*Product Name:*      *M Multi-Application for Life Insurance*  
*Project Name/Number:*      */*

## **Disposition**

Disposition Date: 10/31/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NWPA-125869610 State: Arkansas

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Form	M Multi-Application for Life Insurance		Yes

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## Form Schedule

Lead Form Number: LAA-0109M1

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LAA-0109M1	Application/ M Multi-Application Enrollment for Life Insurance Form	Initial		44	LAA-0109M1.pdf



# NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Life Insurance

P.O. Box 182835, Columbus, Ohio 43218-2835

## PART A – CLIENT INFORMATION

<b>1. Proposed Primary Insured</b>	Name (First, MI, Last) <span style="float: right;">John D. Doe</span>						SSN / Tax ID # 000 - 00 - 0000	
	Address <span style="float: right;">One Any Street</span>						City <span style="float: right;">Any City</span>	
	State Any State	Zip Code 00000	County Any County		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Former Name		
	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other				Age 35	Date of Birth (mm/dd/yyyy) 02/07/1973		State of Birth OH
	Citizenship (*If other, submit Foreign Supplement.) <input checked="" type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.?						Driver's License # / State of Issue RL000000 OH	
	Occupation Any Occupation		Employer Any Employer			Daytime Phone ( 000 ) 000-0000 <input type="checkbox"/> Business <input checked="" type="checkbox"/> Cell <input type="checkbox"/> Home		
	E-Mail Address <span style="float: right;">JDDOE@YAHOO.COM</span>						Evening Phone ( 000 ) 000-0000 <input type="checkbox"/> Business <input type="checkbox"/> Cell <input checked="" type="checkbox"/> Home	

<b>2. Proposed Additional Insured</b>  <i>If applicable, complete for either: a) Joint Insured for Survivorship Life Plan; or b) Term Rider on Another Covered Person (i.e., Spouse/Children)  If additional space is required, use Special Instructions Section.</i>	Name of Insured(s)	Birth Date	Birth State	Sex	Height	Weight	SSN / Tax ID #	Relationship to Insured
	<b>Joint/Spouse Proposed Additional Insured Information Only</b>							
	Former Name		Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)					
	City		State		Zip Code		County	
	Citizenship (*If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.?						Driver's License # / State of Issue	
	Occupation		Employer			Daytime Phone (     ) <input type="checkbox"/> Business <input type="checkbox"/> Cell <input type="checkbox"/> Home		
	E-Mail Address					Evening Phone (     ) <input type="checkbox"/> Business <input type="checkbox"/> Cell <input type="checkbox"/> Home		

<b>3. Owner</b>  <i>Complete ONLY if Owner is not the Proposed Primary Insured.  Unless indicated the Proposed Primary Insured (Joint Insureds in the case of Survivorship) will own the policy.  If more than two Owners are requested, use Special Instructions Section.     TRUST - Submit a copy of first and signature pages of Trust document.</i>	Name (First, MI, Last)						SSN / Tax ID #	
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)						City	
	State	Zip Code	County		Relationship to Insured		Date of Birth (mm/dd/yyyy)	
	E-Mail Address				Phone (     ) <input type="checkbox"/> Business <input type="checkbox"/> Cell <input type="checkbox"/> Home			
	<i>If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The SSN shown above will be used unless otherwise instructed.</i>							
	Joint Owner (First, MI, Last)						SSN / Tax ID #	
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)						City	
	State	Zip Code	County		Relationship to Insured		Date of Birth (mm/dd/yyyy)	
	E-Mail Address				Phone (     ) <input type="checkbox"/> Business <input type="checkbox"/> Cell <input type="checkbox"/> Home			
	Exact Name of Trust			Trust Tax ID Number		Current Trustee(s)		Date of Trust



<b>4. Contingent Owner</b> <i>Complete this section to name an alternative Owner in the event the Insured survives the Owner.</i>	Name (First, MI, Last)				SSN / Tax ID # - -			
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)					City		
	State	Zip Code	County	Relationship to Insured	Date of Birth (mm/dd/yyyy)			
<b>5. Primary Beneficiary Designations</b>  <i>If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary.</i>  <i>If additional space is required, use Special Instructions Section.</i>	<i>When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.</i>							
	<input type="checkbox"/> <i>Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.</i>							
	<b>For Proposed Primary Insured</b>							
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)		Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #		
	Jane S. Doe		100	Wife	10/08/1975	000-00-0000		
	<b>For Proposed Additional Insured</b>							
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)		Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #		
<b>6. Contingent Beneficiary Designations</b>	<b>For Proposed Primary Insured</b>							
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)		Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #		
	Bambi J. Doe		50	daughter	06/20/1996	000-00-0000		
	Moose D. Doe		50	Son	04/08/1998	000-00-0000		
	<b>For Proposed Additional Insured</b>							
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)		Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #		
<b>PART B – INSURANCE INFORMATION</b>								
<b>7. Replacement and Other Policy Information</b>  <div style="text-align: center; color: white; background-color: red; width: 20px; margin: 0 auto; padding: 2px;">STOP</div> <i>Be sure to answer all questions. If applicable, check the appropriate box.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	a. Do you currently have any other Life Insurance or Annuities in force? (If "yes", list below.)						
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b. Is any person here proposed for coverage now applying for Life Insurance or Annuities with any other company? (If "yes", provide name of Company, amount applied for and purpose of coverage.)						
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	c. Will any Life Insurance or Annuities for this or any other company be replaced, discontinued, reduced or changed if insurance now applied for is issued? (If "yes", list below and complete appropriate replacement forms. If this is an IRC Sect 1035 Exchange, attach 1035 forms.)						
Insured	Company	Policy Number	Amount Of Coverage	Year Issued	To Be Replaced	1035 Exch	Nationwide Term Conversion	
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	



# PART C - PLAN INFORMATION

## 8. Life Insurance Plan

Refer to the Illustration for the correct plan name.

- ☐ Nationwide Marathon<sup>SM</sup> Performance VUL – Protection  
☐ Nationwide Marathon<sup>SM</sup> Performance VUL – Accumulation  
☐ Nationwide Marathon<sup>SM</sup> ULTIMATE UL  
☐ Nationwide YourLife<sup>SM</sup> Protection VUL  
☐ Nationwide YourLife<sup>SM</sup> Accumulation VUL  
☐ Nationwide YourLife<sup>SM</sup> ULTIMATE UL  
☐ Nationwide YourLife<sup>SM</sup> Accumulation UL

- ☐ Nationwide YourLife<sup>SM</sup> SUL  
☐ Nationwide YourLife<sup>SM</sup> 20-Pay WL  
☐ Nationwide YourLife<sup>SM</sup> WL 100  
☐ Nationwide YourLife<sup>SM</sup> 10-year Term  
☐ Nationwide YourLife<sup>SM</sup> 20-year Term  
☐ Nationwide YourLife<sup>SM</sup> 30-year Term  
☐ Other \_\_\_\_\_

*\*If a Variable Life product is being applied for, the Variable Life Fund Supplement **MUST** be completed.*

Base Specified Amount	+	Additional Term Rider Amount (Variable Universal Life case only)	=	Total Specified Amount (including Additional Term Rider)
\$ 250,000.00		\$		\$ 250,000.00



**\*\*Complete the Death Benefit and Internal Revenue Code Life Insurance Qualification Test sections if you applied for an Individual Variable Universal, Universal or Survivorship Life Plan.**

### \*\*Death Benefit Option (If no option is selected here, Option 1 is elected.)

- ☒ Option 1 ..... (The Specified Amount, or a multiple of the Cash/Accumulated Value, whichever is greater.)  
☐ Option 2 ..... (The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated Value, whichever is greater.)  
☐ Option 3 ..... (The Specified Amount, plus the Accumulated Premium Account at \_\_\_\_\_%\* interest or a multiple of the Cash/Accumulated Value, whichever is greater.) *\*Enter a percentage up to 12% maximum, ONLY if the Owner is a business entity. If nothing is entered or the Owner is not a business entity, 0% will apply.*

### \*\*Internal Revenue Code Life Insurance Qualification Test Option

- ☒ Guideline Premium/Cash Value Corridor Test  
☐ Cash Value Accumulation Test  
*(If no selection is made here, the Guideline Premium/Cash Value Corridor Test is elected.)*

## 9. Optional Benefits

Select the appropriate benefit according to the illustration.

### Variable or Universal Life Plans Only (Subject to Plan availability.)

- |  |  |
|--|--|
| <input type="checkbox"/> Spouse Rider ..... \$ _____<br><input type="checkbox"/> Children's Term Insurance Rider ..... \$ _____<br><input type="checkbox"/> Long Term Care Rider* ..... \$ _____<br><i>*Complete Supplement for Long Term Care Rider.</i><br><input type="checkbox"/> Premium Waiver Rider ..... \$ _____<br><input type="checkbox"/> Waiver of Monthly Deductions Rider<br><input type="checkbox"/> Extended Death Benefit Guarantee Rider<br>_____ Guarantee Percentage (Indicate percentage of specified amount)<br>_____ Guarantee Duration (Indicate number of years)<br><input type="checkbox"/> Accidental Death Benefit Rider ..... \$ _____ | <input type="checkbox"/> Adjusted Sales Load Rider _____%<br><i>(in whole percentages only)</i> waived for _____ years<br><input type="checkbox"/> Surrender Value Enhancement Benefit<br><input type="checkbox"/> Change of Insured Rider<br><input type="checkbox"/> Other Rider(s) _____<br><input type="checkbox"/> Other Rider(s) _____<br><b>Surrender charge options are available with the Nationwide Marathon Performance – Accumulation Version only. If an option below is not selected, standard surrender charges will be applied.</b><br><input type="checkbox"/> Full Surrender Charge Waiver Option<br><input type="checkbox"/> Partial Surrender Charge Waiver Option |
|--|--|

### Survivorship Variable or Survivorship Universal Life Plans Only (Subject to Plan availability.)

- |   |  |
|---|--|
| <input type="checkbox"/> Four Year Term Rider* ..... \$ _____<br><i>*If the <b>No Charge Four Year Term Insurance</b> has been illustrated you should <b>NOT</b> select this rider.</i> | <input type="checkbox"/> Policy Split Option Rider<br><input type="checkbox"/> Other Rider(s) _____<br><input type="checkbox"/> Other Rider(s) _____ |
|---|--|

### Whole or Term Life Plans Only (Subject to Plan availability.)


- |   |  |
|---|--|
| <input type="checkbox"/> 20 Year Spouse Rider ..... \$ _____<br><input type="checkbox"/> Children's Term Insurance Rider ..... \$ _____<br><input type="checkbox"/> Accidental Death Benefit Rider ..... \$ _____<br><input type="checkbox"/> Guaranteed Insurability Benefit Rider .. \$ _____<br><input type="checkbox"/> Waiver of Premium Disability Benefit Rider<br><input type="checkbox"/> Owner's Waiver of Premium Death Benefit Rider<br>(Complete Part E for the Owner)<br>Occupation _____<br>Height _____<br>Weight _____<br>State of Birth _____ | <input type="checkbox"/> Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part E for the Owner)<br>Occupation _____<br>Height _____<br>Weight _____<br>State of Birth _____<br><input type="checkbox"/> Other Rider(s) _____<br><input type="checkbox"/> Other Rider(s) _____<br><b>Policy will be issued with Automatic Premium Loan Option (APL) for Whole Life Plans only, if available, unless the box below is checked.</b><br><input type="checkbox"/> No, do not issue with APL. |
|---|--|



**PART D - PREMIUM AND BILLING INFORMATION**

<b>10. Initial Premium Payment</b>	<i>(Be sure to review Temporary Insurance Agreement to verify if the Proposed Insured qualifies to submit premium with the application.)</i> Initial Premium Payment \$ 5,000.00 (paid with application) <b>NOTE:</b> Make all checks payable to <b>NATIONWIDE</b> .										
<b>11. Billing and Premium Information</b>	<b>Monthly Electronic Billing Option:</b> <input checked="" type="checkbox"/> Monthly EFT ..... \$ 500.00      Draft Options: <i>(NOTE: Monthly Draft Day will be determined based upon policy effective date unless a day is requested below.)</i> Monthly Draft Day (1 <sup>st</sup> – 28 <sup>th</sup> ): _____ <input checked="" type="checkbox"/> *Checking - Use information on the Premium Check. <input type="checkbox"/> *Checking - (Attach a pre-printed Voided Check.) <input type="checkbox"/> *Savings - (Attach a Voided Deposit Slip with account number and routing number.)  If no check or deposit slip provided, indicate below the bank information to be used: Financial Institution Name Any Institution      Transit/ABA Number 000000000000 Account Number 000000000000      Type of Account: <input checked="" type="checkbox"/> *Checking <input type="checkbox"/> *Savings <i>*By providing my financial institution name and account information, I hereby authorize Nationwide Life and Annuity Insurance Company to initiate debit entries to my checking/savings account indicated above and the Financial Institution to debit the same such account.</i> <b>Additional Billing and Payment Options (check the applicable billing or payment option(s) and indicate the premium amount):</b> <table border="0"><tr><td><input type="checkbox"/> Quarterly ..... \$ _____</td><td><input type="checkbox"/> Billing Advantage ..... \$ _____</td></tr><tr><td><input type="checkbox"/> Semi-Annual ..... \$ _____</td><td>Account Number _____</td></tr><tr><td><input type="checkbox"/> Annual ..... \$ _____</td><td><input type="checkbox"/> 1035/Replacement ..... \$ _____</td></tr><tr><td><input type="checkbox"/> Single Premium ..... \$ _____</td><td><input type="checkbox"/> Other ..... \$ _____</td></tr></table>			<input type="checkbox"/> Quarterly ..... \$ _____	<input type="checkbox"/> Billing Advantage ..... \$ _____	<input type="checkbox"/> Semi-Annual ..... \$ _____	Account Number _____	<input type="checkbox"/> Annual ..... \$ _____	<input type="checkbox"/> 1035/Replacement ..... \$ _____	<input type="checkbox"/> Single Premium ..... \$ _____	<input type="checkbox"/> Other ..... \$ _____
<input type="checkbox"/> Quarterly ..... \$ _____	<input type="checkbox"/> Billing Advantage ..... \$ _____										
<input type="checkbox"/> Semi-Annual ..... \$ _____	Account Number _____										
<input type="checkbox"/> Annual ..... \$ _____	<input type="checkbox"/> 1035/Replacement ..... \$ _____										
<input type="checkbox"/> Single Premium ..... \$ _____	<input type="checkbox"/> Other ..... \$ _____										
<b>12. Payor</b>	<i>If someone other than the Insured(s) or the Owner is billed for the premium for this policy.</i> Name (First, MI, Last) _____ Address _____ City _____ State _____ Zip Code _____										

**PART E - PERSONAL INFORMATION**

<b>13. Tobacco Use</b> <i>All questions are to be answered by each Proposed Insured.</i>  <i>Be sure to answer this section.</i>	<b>Have you used tobacco or nicotine in any form:</b>		<b>Proposed Primary Insured</b>	<b>Proposed Additional Insured</b>
	a. In the last 5 years?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. In the last 12 months?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If "yes", date last used. _____</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "yes", date last used. _____</i>
c. If "yes", check all forms of tobacco or nicotine products used.		<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Snuff <input type="checkbox"/> Nicotine Products (gum, patch, etc.)		<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Snuff <input type="checkbox"/> Nicotine Products (gum, patch, etc.)
<b>14. Physical Measurements</b> <i>Fill in information for the Proposed Primary Insured.</i>	<b>Height</b> 6 ft. 1 in.	<b>Current Weight</b> 185 lbs.	<b>Weight 1 Year Ago</b> 185 lbs.	<b>Reason for Weight Gain or Loss</b>
<b>15. Personal Physicians</b> <i>If Child Rider coverage is requested, use Special Instructions Section to add Personal Physician information for each child.</i>	<b>Proposed Primary Insured</b>		<b>Proposed Additional Insured</b>	
	Name of Personal Physician:		Dr. John Doctor	
	Address:		0000 Industrial Drive Any City, Any State 00000	
	Telephone Number:		(614) 000-0000	
	Date last consulted:		January 10, 2008	
	Reason last consulted:		Physical	
Treatment given or medication prescribed:		none		




<b>16. Personal Details</b> <i>Explain all "yes" answers in Details box below unless instructed otherwise.</i>	<b>All questions are to be answered by each Proposed Insured.</b>			<b>Proposed Primary Insured</b>	<b>Proposed Additional Insured</b>	<b>Any Child</b>
				Yes No	Yes No	Yes No
	a.	Have you ever had any application for Life or Health Insurance (or for reinstatement for Life or Health Insurance) declined, postponed, rated-up or limited?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	b.	Have you ever applied for or received disability payments for any illness or injury?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	c.	In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member; organized racing of an automobile, motorcycle, or any type of motor-powered vehicle, scuba diving, mountain climbing, hang gliding, parachuting, sky diving, bungee jumping or any type of body-contact or life-threatening sport? <i>(If "yes", complete an Aviation/Hazardous Activities Questionnaire.)</i>		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	d.	Have you ever had your driver's license suspended or revoked; or been convicted of driving while impaired or intoxicated, or been convicted in the past 3 years of more than one moving violation?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	e.	Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? <i>(If "yes", complete Drug Questionnaire.)</i>		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	f.	Have you ever been charged with a violation of any criminal law?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	g.	Have you had any bankruptcies in the past 7 years or do you have any suits or judgments pending against you at this time?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	h.	Do you plan to travel or reside outside of the United States or Canada? <i>(If "yes", complete Supplement for Foreign Nationals or Travel.)</i>		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	i.	Do you belong to or intend to join any active or reserve military or naval organization? <i>(If "yes", complete Military Status Questionnaire.)</i>		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	j.	To the best of your knowledge, do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? <i>(If "yes", provide relationship to Proposed Insured(s), age at death and cause of death, and if cancer, provide type.)</i>		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	k.	Have you been involved in any discussion about the possible sale or assignment of this policy to a life settlement, viatical, or other secondary market purchaser?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	l.	Have you ever sold any life insurance policy to a life settlement, viatical, or other secondary market purchaser?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	m.	Will any portion of the current or future premium for this policy be financed?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
n.	Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
<b>17. Explanation of Personal Details</b> <i>If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</i>	<b>Question Letter</b>	<b>Person</b>	<b>Dates</b>	<b>Details</b>		



<b>18. Health Questions</b> <i>All questions are to be answered by each Proposed Insured.</i>  <i>Explain all "yes" answers in Details box below unless instructed otherwise.</i>	<b>To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:</b>			<b>Proposed Primary Insured</b> Yes No	<b>Proposed Additional Insured</b> Yes No	<b>Any Child</b> Yes No
	a.	AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	b.	Heart disease including heart attack, angina, or other chest pain, high blood pressure, shortness of breath, palpitations, heart murmur, phlebitis, or any other disorder of the heart or blood vessels?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	c.	Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	d.	Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	e.	Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	f.	Colitis, ulcer, persistent diarrhea, rectal bleeding, or any other disease or disorder of the esophagus or digestive tract?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	g.	Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	h.	Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	i.	Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	j.	Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	k.	Alcoholism, narcotic addiction, drug use, or hallucinations?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	l.	Any disease or disorder of the eyes, ears, nose or throat?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	<b>To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:</b>					
	m.	Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? <i>(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)</i>		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	n.	Had any disease, disorder, injury, or operation not already disclosed on this application?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	o.	Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	p.	Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?		<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>19. Details of Health History</b> <i>If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</i>	Question Letter	Person	Dates	<b>Details</b> <i>(Be specific. Give full names, addresses and telephone number (if available) of physicians, hospitals, etc.)</i>		



<b>20. Special Instructions Section</b>  <i>If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</i>	
<b>21. Taxpayer ID Number</b>    <i>Check box, if applicable</i>	<p>I certify under penalties of perjury that:</p> <ul style="list-style-type: none"> <li>• The number shown on this form is my correct taxpayer identification number and,</li> <li>• I am not subject to backup withholding because <ul style="list-style-type: none"> <li>♦ I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or</li> <li>♦ the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and</li> </ul> </li> <li>• I am a U.S. person (including a U.S. resident alien).</li> </ul> <p><input type="checkbox"/> Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.</p> <p>The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.</p>
<b>PART F – FRAUD STATEMENTS AND IMPORTANT NOTICES</b>	
<b>ARKANSAS only:</b>	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
<b>COLORADO only:</b>	<b>IMPORTANT NOTICE – IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.</b>
<b>RHODE ISLAND and WYOMING only:</b>	Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.
<b>Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970</b>	<p>This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:</p> <ul style="list-style-type: none"> <li>• An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and</li> <li>• You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing.</li> <li>• Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, P.O. Box 182835, Columbus, Ohio 43218-2835. In the event of an adverse decision, you will be notified in writing.</li> </ul>
<b>Medical Information Bureau Disclosure Notice</b>	Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642). The e-mail address of the Bureau's information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.





**PART G – AGREEMENT AND AUTHORIZATION**

**PART H - SIGNATURES AND PRODUCER'S CERTIFICATION**

Proposed	I HAVE READ THIS APPLICATION AND AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.
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Producer's	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. I have truly and accurately recorded all Proposed Insureds' answers on this application.
------------	---	---

Be sure to answer

*all three questions*


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**TEMPORARY INSURANCE AGREEMENT**  
**NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH**

This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

**HEALTH QUESTION**

  <i>Question must be answered.</i>	<b>Proposed Primary Insured</b>		<b>Proposed Additional Insured</b>		<b>Any Child</b>		<b>Has anyone here proposed for insurance:</b>  Within the past 10 years, been treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; Acquired Immune Deficiency Syndrome (AIDS), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?
	Yes	No	Yes	No	Yes	No	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

*If the above question is answered YES or LEFT BLANK, NO COVERAGE will take effect under this Agreement and no representative of Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.*

**TERMS AND CONDITIONS**

<b>Amount of Coverage</b>  <i>[\$1,000,000] overall maximum for all applications or agreements.</i>	Temporary Insurance under this Agreement will commence on the date of the application if the full first premium for the mode selected has been paid and accepted by Nationwide or authorized by Electronic Funds Transfer as advance payment for an application for Life Insurance. If any Proposed Insured dies while this temporary insurance is in effect, Nationwide will pay to the designated Beneficiary the lesser of: <ul style="list-style-type: none"> <li>the amount of death benefits, if any, which would be payable under the policy and its riders if issued as applied for, excluding any accidental death benefits, or</li> <li><b>[\$1,000,000]</b> This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.</li> </ul>
<b>Date Coverage Terminates</b>  <i>60 DAYS maximum coverage.</i>	Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: <ul style="list-style-type: none"> <li><b>60 days</b> from the date of this signed Agreement, or</li> <li>the date any policy is offered or issued to the Proposed Insured in connection with the above application, or</li> <li>the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.</li> </ul>
<b>Limitations</b>	<ul style="list-style-type: none"> <li>Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidates this Agreement and Nationwide's only liability is for refund of any payment made.</li> <li>This Agreement does not provide coverage for Proposed Insured's who are under 15 days of age or over the age of 70 on the date of the Agreement.</li> <li>If any Proposed Insured dies by suicide, while sane or insane, Nationwide's liability under this Agreement is limited to a refund of the payment made.</li> <li>There is no coverage under this Agreement if the check submitted as payment is not honored by the bank on first presentation or if the Electronic Funds Transfer is not processed by the bank.</li> <li>No one is authorized to waive or modify any of the provisions of this Agreement.</li> </ul>

**SIGNATURES**

<b>Proposed Insured(s) and Owner Signatures</b>	I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.		
	Dated (mm/dd/yyyy) <u>July 28, 2008</u> X <u>John D. Doe</u> <div style="text-align: right; margin-right: 50px;"><i>Signature of Proposed Primary Insured</i></div> <div style="text-align: right; margin-right: 50px;"><i>(or parent if Proposed Primary Insured is under age 15)</i></div>		
	X _____ <div style="text-align: center;"><i>Signature of Applicant/Owner</i></div> <div style="text-align: center;"><i>(if other than the Proposed Insured(s))</i></div>	X _____ <div style="text-align: center;"><i>Signature of Proposed Additional Insured</i></div> <div style="text-align: center;"><i>(if to be Insured)</i></div>	
<b>Initial Premium Receipt and Producer's Signature</b>	An initial premium payment in the amount of \$ <u>5,000.00</u> has been submitted with this application. I have advised the Applicant/Owner that additional premium may need to be submitted at time of delivery.		
	X <u>Sam A. Producer</u> <div style="text-align: center;"><i>Signature of Producer</i></div>	Any Firm _____ <div style="text-align: center;"><i>Firm</i></div>	<u>02-A000000</u> <div style="text-align: center;"><i>Producer's Nationwide #</i></div>



<i>SERFF Tracking Number:</i>	<i>NWPA-125869610</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Nationwide Life and Annuity Insurance Company</i>	<i>State Tracking Number:</i>	<i>40725</i>
<i>Company Tracking Number:</i>	<i>LAA-0109M1</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>M Multi-Application for Life Insurance</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: NWPA-125869610 State: Arkansas  
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 40725  
Company Tracking Number: LAA-0109M1  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: M Multi-Application for Life Insurance  
Project Name/Number: /

## Supporting Document Schedules

**Review Status:**  
**Satisfied -Name:** Certification/Notice 10/22/2008  
**Comments:**  
**Attachment:**  
AR Cert.pdf

**Review Status:**  
**Satisfied -Name:** Application 10/22/2008  
**Comments:**  
Application L-4736-99 approved on 01/15/2003.



ARKANSAS

Certificate of Compliance

Insurer Nationwide Life and Annuity Insurance Company

Form Numbers: LAA-0109M1 Multi-Application for Life Insurance

I have reviewed or supervised the review of the above forms. To the best of my knowledge and belief, they are in compliance with the rules and requirements of Regulation 19 and 49 of the Arkansas Statute, ACA 23-80-206, ACA 23-79-138, and Bulletin 11-88.

You have our assurance that any maximum cost of insurance changes and/or any minimum accumulation rates will be re-filed with the department

These forms also meet the Flesch readability requirements as explained in Title 23-80-206 of the Arkansas Insurance Code.

A handwritten signature in black ink, appearing to read "John H. Crow".

\_\_\_\_\_  
John H. Crow, ChFC, CLU, FLMI  
Associate Vice President  
NF Compliance  
Date: 10/28/2008

**NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY**

Home Office: One Nationwide Plaza • Columbus, Ohio 43215-2220